

0032/035

PRINTED: 05/31/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNPL53766	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/18/2011
NAME OF PROVIDER OR SUPPLIER CARESTONE AT RIVERGATE		STREET ADDRESS, CITY, STATE, ZIP CODE 94 TWIN HILLS DRIVE MADISON, TN 37115		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D1218	Continued From page 30 Review of facility folder holding the resident's record revealed the resident expired on December 29, 2009. Continued medical record review revealed no nursing notes to document events leading up to the resident's demise or the date and time of discharge from the facility. During interview on May 18, 2011, at 2:45 p.m., in the administrative office, the General Manager confirmed documentation was not present to clarify discharge information. COMPLAINTS 24094, 24798, 25151, & 26013	D1218	Complaints 24094, 24798, 25151, & 26013 1200-08-25.12 (4) Resident Records D1222	
D1222	1200-08-25-12 (4) Resident Records (4) An ACLF shall complete a written assessment of the resident to be conducted by a direct care staff member within a time-period determined by the ACLF, but no later than seventy-two (72) hours after admission. This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to conduct and /or document a resident assessment for two (#9, #29) of thirty-five residents reviewed. The findings included: Medical record review revealed resident #9 was admitted to the facility on June 26, 2009. Continued medical record review revealed no resident assessments to determine the functional capabilities of the resident were present in the record. Medical record review revealed resident #29 was	D1222	Administrator and/or designee will audit new admissions to ensure resident assessments are conducted prior to or no later than 72 hours after resident is admitted to the facility and will ensure assessment is accurate and complete for each individual resident being admitted into the facility. Resident #9 wellness director and/or designee shall ensure current assessment is present in the chart by 06/30/2011. Resident #29 wellness director and/or designee shall ensure current assessment is present in the chart by 06/30/2011.	7-2-11

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D1222	Continued From page 31 admitted to the facility on May 27, 2008. Continued medical record review revealed an undated Resident Assessment which was incomplete as well as a monthly assessment dated April 8, 2011, which was also incomplete. During interview on May 18, 2011, at 2:45 p.m., in the administrative office, the General Manager confirmed the absence of assessments in the resident's record.	D1222		
D1301	1200-08-25-.13 (1) Reports (1) Unusual events shall be reported to the Department of Health by the ACLF in accordance with T.C.A. §§ 68-11-211, et seq. This Rule is not met as evidenced by: Based on medical record review, facility incident report review, and interview, the facility failed to report significant events involving residents to the Unusual Incidents Reporting System for three (#12, #27, #28) of thirty-five residents reviewed. The findings included: Medical record review revealed resident #12 was present in the facility on February 4, 2009, according to a hospital admission form which stated the resident had a history of Hypertension, Dementia, Hyperlipidemia, COPD (Chronic Obstructive Pulmonary Disease) and Glaucoma. Continued medical record review revealed no other documentation from the resident's stay in the facility before December 1, 2009. Medical record review revealed no nursing notes before December 1, 2009, and no other medical record before that date. Continued medical	D1301	1200-08-25-.13 (1) Reports D1301 Administrator and/or designee will report all unusual occurrences using URIS reporting system as required and outlined in the regulations. Complaints 24573 & 26005	

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D1301	<p>Continued From page 32</p> <p>record review of a nursing note dated December 1, 2009, revealed "...x-ray of rt. (right) arm ordered". Further medical record review of an x-ray dated December 2, 2009, revealed "...right forearm with no acute osseus (bony) abnormality or significant malalignment".</p> <p>Review of facility incident reports revealed no incident reports describing these findings and no investigation of possible abuse. Review of Unusual Incident Reporting System (UIRS) data for 2009 revealed this incident was not reported as possible abuse.</p> <p>Medical record review revealed resident #27 was admitted to the facility on September 30, 2007 with diagnoses including Brittle Diabetes Mellitus, Hypothyroidism, Dementia, and Neurogenic Bladder. Review of a Resident Assessment dated June 28, 2009, revealed the resident used a walker for ambulation; was independent with transfers and toileting; required assistance with dressing; required supervision with bathing; was alert and oriented.</p> <p>Review of undated physician's orders revealed the resident was to receive Lantus Insulin 36 units every morning and the sliding scale was to be changed to: blood sugar 150 - 200 give 6 units insulin; blood sugar 201 - 250 give 8 units insulin; blood sugar 251 - 300 give 12 units insulin; blood sugar 301 - 350 give 16 units insulin; blood sugar 351 - 400 give 20 units insulin; blood sugar greater than 401 give 24 units insulin.</p> <p>Review of facility documentation revealed the resident received the wrong type of insulin and suffered a reaction. Continued review revealed the resident was transferred to the hospital on October 4, 2009, and expired on October 14,</p>	D1301		

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D1301	<p>Continued From page 33</p> <p>2009 with causes of death listed as Anoxic Brain Injury and Severe Hypoglycemia.</p> <p>Review of UIRS for 2009 revealed no documentation this incident was reported as required.</p> <p>Interview with the General Manager on May 11, 2011, at 2:10 p.m., in the library, revealed resident #28 was involved in an accident in 2010 where the wheelchair went down a flight of stairs and the resident sustained a fractured neck. Continued interview revealed the resident was returning to the facility with a halo brace in place but developed complications in the hospital and expired.</p> <p>Attempts to locate the resident's record as well as the incident report were unsuccessful. The General Manager looked in both the storage and file rooms but was unable to locate the record or incident report.</p> <p>Review of the UIRS for 2010 revealed no documentation this incident was reported as required.</p> <p>COMPLAINT 24573 & 26005.</p>	D1301			

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